93-262

No._____

Supreme Court, U.S.
FILED
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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

PATRICIA L. BUELL,

Petitioner,

vs.

SECURITY GENERAL LIFE INSURANCE COMPANY,
AN OKLAHOMA CORPORATION, ET AL.,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

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August 17, 1993

65 pp

QUESTIONS PRESENTED

I. Did the Tenth Circuit Court of Appeals create or contribute to an inter-circuit conflict by erroneously interpreting this Court's "excusable neglect" standard as stated in Pioneer Inv. Services v. Brunswick Associates, ____ U.S. ____, 113 S.Ct. 1489 (1993) to require proof from petitioner that she or her counsel made a diligent yet unsuccessful attempt to discover evidence?

II. Did the Tenth Circuit Court of Appeals create or contribute to an inter-circuit conflict by refusing to apply Colorado law to an insurance dispute even though Colorado had the most significant relationship to the contract?

III. Did the Tenth Circuit Court of Appeals create or contribute to an inter-circuit conflict in dismissing a bad faith insurance case where the insurer reinstated benefits after terminating the insurance policy?

LIST OF PARTIES

The parties to this proceeding, in addition to those that appear in the caption of the case, include American Life and Casualty Insurance Company, an Iowa corporation; American Marketing Services, Inc., formerly known as BeneCenter of Colorado, Inc., doing business as BeneCenter of Colorado, Inc., an Arizona corporation; Benecenter of Colorado, Inc., a Colorado corporation.

RULE 29.1 STATEMENT

As required by Rule 29.1 of this Court, to the best knowledge of the Petitioner, there are no parent or subsidiary companies to be listed herein.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Tenth Circuit, affirming the district court's grant of summary judgment for respondent dismissing petitioner's damage claims and denying her Rule 59(e) motion and reversing the district court's summary judgment in favor of petitioner on the insurance coverage issue is officially published at 987 F.2d 1467 (10th Cir. 1993) and is reprinted in the Appendix at A-29. (References to the appendices bound with this Petition are styled "A-__".) The memorandum decisions of the United States District Court for the District of Colorado, from which this appeal was taken, are reported at 779 F. Supp. 1573, reprinted at page A-1; 779 F. Supp. 1579, reprinted at page A-18; and 784 F. Supp. 1533, reprinted at page A-22.

JURISDICTION

The decision of the Court of Appeals was announced and filed on March 3, 1993. A timely petition for rehearing and suggestion for rehearing en banc was filed on May 19, 1993 (A-40) and denied on May 19, 1993. A-44. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1). This petition for certiorari is being filed under Rules 13.1 and 13.4 of this Court.

RULES IN ISSUE

Rule 59(e) of the Federal Rules of Civil Procedure provides:

> A motion to alter or amend the judgment shall be served not later than 10 days after entry of judgment.

STATEMENT OF THE CASE

1. This is a health insurance dispute falling under diversity jurisdiction. Most of the facts leading to the lawsuit are not disputed. In 1984, petitioner Patricia Buell purchased an insurance certificate from American Life and Casualty Company ("American Life"), a North Dakota company, through Consumer Health Care Association ("CHCA"), a marketing entity located in Oklahoma and her Colorado insurance agent while she was a Colorado resident. Sometime thereafter, respondent Security General Life Insurance ("Security General"), an Oklahoma company, purchased this particular block of insurance business from American Life and assumed all of the rights and responsibilities flowing from the insurance contracts. Petitioner at all times remained a resident of the state of Colorado and paid all insurance premiums from Colorado. In 1986, petitioner was diagnosed with lung cancer and began submitting significant claims to Security General at its Oklahoma offices.

In May, 1990, respondent notified Mrs. Buell that it decided to unilaterally terminate all insurance benefits that might otherwise be due to her because it was experiencing excessive losses on this block of business. Following this notice of termination, Mrs. Buell commenced a state court action for declaratory judgment and other damage claims. The action was removed to federal court by Security General based on diversity jurisdiction. Respondent began paying Mrs. Buell's medical bills pending outcome of the litigation.

Petitioner, given her bad health, filed a motion under state statute which permits a trial calendar preference in cases where it is probable that the applicant may not survive the litigation. Although this statute did not need to be followed in federal court, the district court nevertheless placed this case on an accelerated docket.

2. Cross-motions for summary judgment were filed by petitioner and respondent. Petitioner sought reinstatement of her insurance benefits as well as damages for breach of contract and the covenant of good faith and fair dealing; outrageous conduct; negligent misrepresentation and exemplary damages.

3. On December 6, 1991, the district court granted the petitioner's motion to the extent it declared that she was entitled to continued benefits despite the termination. The district court did, however, grant respondent's cross-motion, and dismissed all of the petitioner's damage claims. The petitioner's motion for summary judgment was granted because the court determined that the policy could reasonably be construed as an injury policy. Thus, a post-injury termination would not affect rights that had already vested. The respondent's motion was granted in part because, in the district court's opinion, it could terminate based on poor claims experience of the entire group.

4. Petitioner immediately filed a Motion for Reconsideration and it was denied on December 11, 1991. A-18. The ruling was based in part on the district court's finding that it was inexcusable neglect for the petitioner not to have filed the necessary evidence prior to the deadline of December 2, 1991 as ordered by the Court.

5. On December 16, 1991, the petitioner filed a motion to reconsider and to review taxation of costs. These motions were denied by the district court on February 24, 1992. A-22.

6. On appeal to the Tenth Circuit, petitioner attacked the district court's refusal to permit the introduction of additional evidence that was central to the factual defense regarding the respondent's poor claim experience. This evidence was offered by petitioner's expert witness who relied upon discovery belatedly supplied to petitioner by respondent.

7. The Tenth Circuit misinterpreted this Court's holding in Clay v. Sun Insurance Office, Ltd., 377 U.S. 179 (1964). In Clay, an issue arose as to which state's law would govern the insurance controversy. There, the Court reversed the Fifth Circuit Court of Appeals that refused to apply Florida law to the controversy since it concluded that Florida did not have ample contacts with the transaction. In reversing, this Court found that since the insurance company was licensed to do business in Florida and because the insured was a resident of Florida, that Florida law should apply given the ample contacts. Here, petitioner was a Colorado resident who purchased insurance through a Colorado insurance broker from respondent's predecessor in interest. While a policy of insurance may not have been delivered to her while she was in Colorado, she did receive a certificate of insurance reflecting the coverage promised in the policy itself. This "certificate" vs. "policy" question was at issue in Oakley v. National Western Life Ins. Co., 294 F. Supp. 504, 508 (S.D.N.Y. 1968). There, the district court followed what is now apparently the majority rule, that the law of the place of delivery of the certificate governs the dispute. See Petitioner's Petition for Rehearing at A-41 citing the various courts that now follow this rule.

8. Which state's law applies is obviously critical since here the district court followed Colorado law in deciding that the insurance at issue covered an "injury"; thus, termination of the insurance would not affect rights that accrued pre-termination. A-6.

9. The Tenth Circuit also misinterpreted this Court's holding in Pioneer Inv. Services v. Brunswick Associates, ____ U.S. ____, 113 S.Ct. 1489 (1993) regarding excusable neglect. The disputed issue of fact that was not entertained by the district court was whether or not respondent's loss ratio experience was tied to a deterioration in health of one or more insureds, or caused by some other circumstance. The belated evidence that was not permitted by the district court would have proven that there was a direct relationship between respondent's high loss ratio experience and the deterioration of the certificateholders' health whose benefits were summarily terminated.

10. Finally, the Tenth Circuit, by its decision, adds to the confusion regarding a tortfeasor's rights to pursue a bad faith claim where an insurance company re-commences benefits post-suit. At least one other circuit has held that the reinstatement of benefits after commencement of the bad faith case does not preclude the continuation of a bad faith action. Berry v. United of Omaha, 719 F.2d 1127 (11th Cir. 1983).

11. Petitioner requests this Court to reverse the Tenth Circuit Opinion and resolve the inter-circuit conflicts addressed above by clarifying the correct rules, namely that:

A. The district court should have accepted the petitioner's late offered evidence because there was a reasonable explanation as to its unavailability, and since it demonstrated a genuine issue of material fact regarding the relationship between the high loss ratio and deterioration of the insureds' health;

B. The law of Colorado applies to this insurance dispute as it has the most significant, ample contacts with the dispute;

C. The reinstatement of benefits by an insurer following the institution of a bad faith action does not preclude the maintenance of the action.

REASONS FOR GRANTING CERTIORARI

This Court should grant Certiorari in this case because fundamentally this petition presents a unique opportunity to resolve several major issues of constitutional impact that either heretofore have not been adequately addressed or that were isinterpreted by the Tenth Circuit:

1. The Tenth Circuit Court of Appeals erroneously interpreted this Court's decision in Pioneer Inv. Services by requiring counsel to prove that he made a diligent yet unsuccessful effort to discover the evidence thereby creating an inter-circuit conflict;

2. The Tenth Circuit Court of Appeals contributed to an inter-circuit conflict by in effect holding that Colorado law may not apply to the insurance dispute at issue; and

3. The Tenth Circuit Court of Appeals contributed to an inter-circuit conflict by holding that reinstatement of benefits following institution of a bad faith tort action renders the action moot.

This writ of Certiorari is thus needed to resolve the important conflicts of law question presented, the ramifications of Pioneer Inv. Services upon civil practice outside the bankruptcy arena, and the critical issue of the cancellation of insurance benefits *vis-a-vis* the maintenance of a bad faith insurance action.

Only certiorari relief from this Court can correct the erroneous ruling of the Tenth Circuit and restore uniformity among the circuits as to the vital issues presented. Because the health insurance crisis is at its peak, an insurance company's power to cancel benefits should be addressed by this Court.

I

The Tenth Circuit Court of Appeals erroneously interpreted this Court's decision in Pioneer Inv. Services by requiring counsel to prove that he made a diligent yet unsuccessful effort to discover the evidence thereby creating an inter-circuit conflict.

The Court of Appeals for the Tenth Circuit applied the wrong "excusable neglect" standard in reviewing the district court's decision not to permit the admission of petitioner's evidence in opposition to the respondent's motion for summary judgment. As this Court recently ruled in Pioneer Inv. Services v. Brunswick Associates, ____ U.S. ____, 113 S.Ct. 1489 (1993), "excusable neglect" contemplates that courts are permitted in appropriate circumstances to accept late filings caused by a variety of reasons, including circumstances beyond the party's control. Here, the lower courts concluded that since petitioner failed to demonstrate a diligent yet unsuccessful effort to discover the evidence, that the evidence could not be offered to oppose the respondent's motion for summary judgment.

The evidence that was unavailable was provided to the petitioner by respondent on November 26, 1991 only a few days before the cut-off date of December 2, 1991 established by the district court for submission of summary judgment materials. This loss ratio data then had to be transmitted to the petitioner's

expert, Joan Ogden, who officed in Salt Lake City, Utah to supplement her previous report. This history is set forth in detail in Plaintiff's Motion to Reconsider the Order Granting Summary Judgment in Favor of Defendant on all issues or in the Alternative, For Leave to File a Supplemental Brief in Reply to Defendants' Response to Plaintiff's December 2, 1991 Brief with Supporting Affidavit of Patty L. Buell and with Memorandum Authority Incorporated Herein December 6, 1991 which is reprinted at A-11.

This evidence would have supported petitioner's opposition to the respondent's motion for summary judgment and buttressed the reasonable inference that should have been given to the petitioner as the non-moving party that a factual dispute existed regarding whether the petitioner's benefits were terminated due to a deterioration in the health of the insured.

As the Court of Appeals observed, the respondent's termination of benefits would be wrongful if it was tied to the deterioration in petitioner's health. Petitioner's expert's affidavit showed durational loss ratio history that raised the genuine factual dispute that over time the petitioner's block of insurance did indeed incur higher loss ratios, the primary cause of which can only be higher claims due to deterioration in health.

The Court of Appeals also defines too narrowly the factual issue in dispute, as termination may be undertaken by an insurance company as long as they discriminate against an entire group of insureds. The logic of this conclusion escapes petitioner - but the implications do not. The Tenth Circuit evidently sanctions wholesale discrimination, a result that seemingly defies all constitutional precepts. Moreover, all reasonable inferences should be given to the petitioner as non-moving party.

As this Court held in Bishop v. Wood, 426 U.S. 341 (1976), the non-movant's version of the facts must be accepted and all disputed matters must be resolved in his favor. Also, as was held in United States v. Diebold, 369 U.S. 654, 655 (1962), all inferences to be drawn from the underlying facts contained in the motion for summary judgment materials must be viewed in the light most favorable to the party opposing the motion.

Since petitioner is a member of the group with high claims experience, it is clear that the cancellation of benefits undertaken by the respondent was tied to the deterioration of her health, as well as all the other insureds in her group who over time began submitting more insurance claims. The Tenth Circuit affirmed a district court decision that failed to view any of the disputed facts in a light most favorable to the petitioner, or to otherwise accept the petitioner's version of the facts.

II

The Tenth Circuit Court of Appeals contributed to an inter-circuit conflict by holding that Colorado law may not apply to the insurance dispute at issue.

The district court correctly ruled that Colorado law applied to this dispute. At issue were Colorado Revised Statutes §§ 10-8-116(2)(b)(V) and 10-8-116(3)(a) (Cum.Supp. 1986). These statutes were relied upon by the district court when it concluded that petitioner was covered by an "injury" type policy and that therefore post-injury termination of benefits by respondent would not affect her right to continued coverage.

The Tenth Circuit concluded erroneously that there was no evidence that the policy was issued for delivery in Colorado. This conclusion is wholly unsupported by the evidence, inasmuch as the petitioner without dispute always remained a resident of Colorado, paid her premiums from Colorado, received benefits while in Colorado, bought the insurance while in Colorado and employed the services of a Colorado insurance agent to procure this coverage.

Moreover, case law supports the view that because insurance matters peculiarly involve matters of local concern, that Colorado law should apply. Pink v. A.A.A. Highway Express, 314 U.S. 201 (1941). Furthermore, even the Tenth Circuit has held that the law of the forum with the most significant relationship to the transaction should govern the dispute. Mitchell v. State Farm Fire & Cas. Co., 902 F.2d 790 (10th Cir. 1990); Budd v. American Excess Ins. Co., 928 F.2d 344 (10th Cir. 1991).

Finally, the fact that respondent delivered to petitioner a certificate of insurance while she was a Colorado resident demonstrates that respondent intended to be governed by Colorado law. Petitioner submits that the Tenth Circuit erred when it concluded that the delivery of a certificate is not tantamount to the delivery of a policy. Oakley v. National Western Life Ins. Co., 294 F. Supp. 504 (S.D.N.Y. 1968).

It is submitted that the law of Colorado does govern this dispute and that the Tenth Circuit erroneously reversed the district court's judgment declaring coverage in favor of petitioner.

III

The Tenth Circuit Court of Appeals contributed to an inter-circuit conflict by holding that reinstatement of benefits following institution of a bad faith tort action renders the action moot.

The decision to dismiss the petitioner's damage claims turned on the argument that the respondent could terminate benefits for any reason, or no reason at all, as long as it was not done solely on the grounds of the deterioration of health of the insured, and because the respondent continued to pay petitioner's benefits following commencement of this litigation. First, the reason for the termination of benefits was solely due to the high claims experience of the certificateholders, and ipso facto due to the deterioration of health of those same group of individuals of which petitioner was a member. Thus, it is clear that respondent violated its own contract of insurance.

Furthermore, petitioner brought this civil action to stop respondent from terminating benefits that it previously agreed to pay. As was noted in Berry v. United of Omaha, 719 F.2d 1127 (11th Cir. 1983) referencing the tort of conversion: "Return of the chattel . . . does not bar the action, but goes merely to reduce the damages." Id. at 1129. Colorado followed Berry and adopted it in Farmers Group, Inc. v. Trimble, 691 P.2d 1138, 1142 (Colo. 1984) when it stated, quoting Berry:

> [i]f the action accrues at the point when payment is refused, the elements of the tort [breach of duty of good faith] are satisfied on such refusal, and the continuing condition of nonpayment cannot be a predicate to a bad faith cause of action.

RELIEF REQUESTED AND CONCLUSION

Petitioner respectfully requests that this Honorable Court grant Certiorari to correct the Tenth Circuit's errors as stated above, clarify the Court's holding in Pioneer Investment Services, and to resolve the existing conflicts among the circuits as elucidated herein.

Petitioner respectfully requests that this Court grant this Petition for Certiorari, summarily reverse the decision of the Tenth Circuit, and reinstate the decision of the district court to the extent it declares coverage in favor of the petitioner.

Petitioner alternatively respectfully requests that this Court grant Certiorari and remand this case to the Tenth Circuit with instructions to reconsider for the reasons set forth herein.

Dated this 17th day of August, 1993.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

PATRICIA L. BUELL,	)	
	)	Case No. 91-B-868
Plaintiff,	)	
	)	
v.	)	
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation, et al.,	)	
	)	
Defendants.	)	

MEMORANDUM OPINION AND ORDER

Beginning in 1984, plaintiff Patricia L. Buell (Buell) had a group insurance policy with defendants. In 1986, she was diagnosed with lung cancer. In 1990, defendants terminated the group policy. Defendants, although continuing to pay Buell's medical expenses, contend that they are not required to do so. Buell sued in Colorado state court seeking a declaratory judgment that she is covered under the policy as well as damages for breach of contract, breach of implied covenant of good faith and fair dealing, negligent misrepresentation, and outrageous conduct. The action was removed to this court and jurisdiction exists on diversity of citizenship.

Cross motions for summary judgment have been filed. I conclude that the policy is uncertain with respect to coverage and, therefore, must be construed against defendants. Accordingly, I grant Buell's motion for summary judgment on her declaratory judgment claim. However, because defendants have continued to reimburse Buell for her medical expenses, there has been no breach

of contract, no breach of the implied covenant of good faith and fair dealing, no negligent misrepresentation, and no outrageous conduct. Accordingly, I grant defendants' motion on these claims.

I. SUMMARY JUDGMENT STANDARD

Federal Rule of Civil Procedure 56(c) mandates the entry of summary judgment if there is no genuine dispute of material fact and the moving party is entitled to judgment as a matter of law. "The plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett,* 477 U.S. 317, 322, 106 S.Ct. 2548, 2552, 91 L.Ed.2d 265 (1986). To make a sufficient showing, the nonmovant must come forward with enough evidence to permit a reasonable jury to find that the essential element has been established. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250, 106 S.Ct. 2505, 2511, 91 L.Ed.2d 202 (1986).

II. FACTS

There is no genuine dispute of material fact. In 1983, defendant American Life and Casualty Insurance Company (American Life) delivered to Consumer Health Care Association (CHCA) a group health insurance policy (the policy). In 1984, Buell was issued a Certificate of Group Insurance (the certificate) as evidence of the insurance provided under the policy. The certificate provides in part: "The benefits described in this Certificate are subject to all of the provisions, terms and conditions of the Policy. The Policy alone constitutes the entire contract under which right and benefits are provided." The "Policy Term" section of the policy provides:

> The policy continues in effect from its effective date specified on the face of the policy as long as the premium is paid as provided herein, subject to the

Grace Period as provided in the General Provisions hereof; provided however that: . . .

B. The Company may terminate the policy on any premium date by giving written notice to the Policyholder at least 31 days prior to any premium due date.

C. The Company will not terminate or nonrenew the certificate solely on the grounds of the deterioration of the health of the Insured.

In the "policy Specifications" section, the Policyholder is listed as "Consumer Health Care Association." The premiums were due monthly.

The "Major Medical Benefits" section of the Policy provides:

> When as a result of sickness or accidental bodily injury, an Injured Person incurs Covered Expenses shown herein while this insurance is in force as to such Person, the Company will pay the applicable percentage, shown in the policy Specifications, of such expenses incurred in excess of the Deductible Amount, not to exceed the Maximum Amount.

In 1985, defendant Security General Life Insurance Company (Security General) purchased from American Life the rights and insurance liability risks represented by the policy. From that date, Security General received all premiums and was responsible for all claims incurred under the policy.

In 1986, Buell became permanently disabled with lung cancer.

By letter dated April 26, 1990, Security General notified CHCA that Security General was terminating the entire

group policy effective May 31, 1991. The decision was based upon poor claims experience of the entire group. By letter dated May 19, 1990, Security General notified Buell that after June 19, 1990, her health insurance policy would no longer be in force.

Although Security General disputes that it is required to pay for expenses resulting from Buell's cancer incurred after the policy was terminated, it has continued to provide Buell with benefits under the policy. However, Security General has required that every three months Buell fill out a one-page "Medical Insurance Claim Form" verifying the nature of her claim and the doctors she has consulted in the past 12 months.

III. DISCUSSION

A. *Declaratory Judgment: Must Defendants' Pay for Buell's Medical Expenses?*

The parties agree that this case should be decided according to Colorado law. The parties also agree that Colorado distinguishes between "expense" policies and "injury" or "occurrence" policies. In an "expense" policy, which provides insurance for medical and hospital related expenses as such expenses are incurred, "the insured is not entitled to post-termination benefits beyond the terms providing for extended coverage." *Lister v. American United Life Insurance Company*, 797 P.2d 832, 834 (Colo. App. 1990). In an "injury" or "occurrence" policy, which provides coverage for an injury or illness occurring while the policy is in force, the insured is entitled to post-termination coverage for expenses arising out of that injury or illness. *Loesekan v. Benefit Trust Life Insurance Company*, 552 P.2d 36, 37 (Colo. App. 1976).

The parties dispute whether the policy at issue here is one for expenses or one for injury. In deciding this issue, I follow settled principles of insurance law.

> An insurance policy is a contract which should be interpreted consistently with the well settled principles

> of contractual interpretation. . . In applying these principles, words should be given their plain and ordinary meaning unless the intent of the parties, as expressed in the contract, indicates that an alternative interpretation is intended. Where a contractual provision is clear and unambiguous the court should not rewrite it to arrive at a stained construction. *However, when a contractual provision is reasonably susceptible to different meanings it must be construed against the drafter and in favor of providing coverage to the insured.*

Chacon v. American Family Mut. Ins. Co., 788 P.2d 748, 750 (Colo. 1990) (citations omitted) (emphasis added).

[1,2] Thus, if the policy can reasonably be construed as either an expense policy or an injury policy, then it must be construed against defendants and in favor of coverage. *See id.: United Bank v. Hartford Accident & Indem. Co.*, 529 F.2d 490, 493 (10th Cir.1976) (applying Colorado law) ("where there is ambiguity or uncertainty with respect to coverage, construction will favor the insured"). I conclude that the policy, when read in conjunction with Colorado statutory law, can reasonably be construed as an injury policy. Accordingly, Buell is entitled to summary judgment on her declaratory judgment claim.

Colo.Rev.Stat. §10-8-116(2)(b)(V) reads:

> If the group insurance policy provides hospital, surgical, or major medical insurance or any combination of these coverages on an expense-incurred basis, for other than specified diseases or accidental injuries only, it shall also contain a conversion privilege conforming to the requirements of subsection (3) of this section.

Thus, a group policy that provides coverage on an expense-incurred basis "shall" contain a "conversion privilege." The

policy here does not contain a conversion privilege. Consequently, an insured could reasonably conclude that the policy must be an injury policy and not an expense policy. In addition, the policy does not explain to the insured what happens when the policy terminates. Although the policy can reasonably be construed as one for expenses, I hold that, because it does not contain a conversion privilege and does not explain what happens upon termination, the policy can also reasonably be construed as an injury policy.

Defendants' reliance on *Lister* is misplaced. First, unlike the policy here, the insurance policy at issue in *Lister* contained a conversion privilege. Attachment 1 to Defendants' Exhibit M §5. Moreover, the policy at issue in *Lister* contained an "Extended Benefits" section which explicitly stated the coverage provided when the policy terminated. *Lister,* 797 P.2d at 834. This factor was central to the court's decision. *See id.* Buell's policy contains no "Extended Benefit" section and does not state what coverage, if any, is provided when the policy terminates.

[3] Because the policy "is reasonably susceptible to different meanings," it must be "construed against the drafter and in favor of providing coverage to the insured." *Chacon,* 788 P.2d at 750; *see also Houghton v. American Guar. Life Ins. Co.*, 692 F.2d 289 (3d Cir. 1982). Therefore, a judgment will issue declaring that Buell is entitled to benefits under the policy for expenses incurred as a result of her lung cancer. Because the benefits resulting from Buell's cancer were fixed before the policy's termination, she is not required to make future premium payments. *See Loesekan,* 552 P.2d at 37.

Finally, it is undisputed that only Security General is responsible for claims under the policy. Accordingly, because no other defendant is responsible for providing Buell with coverage, the declaratory judgment will be directed against Security General alone.

B. *Breach of Contract*

Buell claims that she is entitled to breach of contract damages because defendants: (1) failed to pay her for future benefits believed to be $1,000,000; (2) wrongfully terminated the policy; and (3) failed to give her timely notice of the termination as required by the policy.

1. Failure to Pay Buell Future Benefits

[4] As discussed above, the policy requires coverage for Buell's expenses related to her cancer. It is undisputed that Buell has received continuous policy benefits pending the outcome of this case. Thus, the insurance contract has not been breached. Because there is no breach of contract, Buell is entitled to no damages. No reasonable construction of the policy supports Buell's contention that she is entitled to receive covered expenses before those expenses are incurred.

2. Wrongful Termination

[5] Buell also claims that the policy was wrongfully terminated because the termination was based "solely on the grounds of the deterioration of the health of the Insured." By using "Insured" and not "Insureds," the policy allows for termination based on poor claims experience of the entire group. It is undisputed that Security Life terminated the group policy, not because of the claims experience of any one individual, but because of poor claims experience of the entire group. Accordingly, defendants are entitled to summary judgment on this claim.

3. Timely Notice

[6] Next, Buell claims that the termination was wrongful because she was not given proper notice of the termination. No material dispute exists on this claim.

The policy provides in pertinent part: "The Company may terminate the policy on any premium due date by giving written notice to the Policyholder at least 31 days prior to any premium due

date." In the "Policy Specifications" section, the Policy holder is listed as "Consumer Health Care Association." It is undisputed that Consumer Health Care Association was given timely written notice. Consequently, there was no breach. Buell contends that there is a genuine dispute of fact concerning whether Buell was given 31 days notice, or only 30. this dispute is not material because the policy requires that notice be given to CHCA and not to Buell.

C. *Covenant of Good Faith and Fair Dealing*

In response to defendants' motion for summary judgment, Buell points to four theories to support her breach of the implied covenant of good faith and fair dealing claim: (1) insufficient notice being given regarding termination of her certificate; (2) termination of her certificate solely on the grounds of deterioration of the health of the insured; (3) being singled out when her certificate was terminated; and (4) requiring her to fill out the one-page "Medical Insurance Claim Form" every three months. *See* Plaintiff's Reply at 12; Plaintiff's Brief Pursuant to Court Order at 2. All of these theories fail as a matter of law.

I have already concluded that the first and second theories are without merit. As to the third ground, being singled out, the evidence is uncontroverted that everyone who was insured under the policy was terminated. Accordingly, this theory is also without merit.

[7] The theory based on the one-page information sheet also fails. In Colorado, breach of the covenant of good faith and fair dealing "does not generally give rise to an independent tort claim." *Friedman v. Colorado Nat'l Bank*, No. 90CA0248, 1991 WL 143506, at "9 (Colo.App. Aug. 1, 1991). Colorado has recognized an exception to this rule where an insurer unreasonably denies or delays payments of a claim. *Farmers Group, Inc. v. Trimble*, 691 P.2d 1138, 1142 (Colo. 1984). I am aware of no Colorado court expanding this tort to cover a theory such as Buell's.

However, even assuming that such a theory gives rise

to a cognizable claim, I conclude that Buell's claim is legally insufficient. "The question of whether an insurer has breached its duties of good faith and fair dealing with its insured is one of reasonableness under the circumstances." *Id.* Buell has continued to receive insurance benefits. Consequently, her insurer has a right, periodically, to be apprised of her medical status. I conclude that no reasonable jury could find that the periodic notification requirement is unreasonable. Accordingly, this claim fails as a matter of law.

D. *Outrageous Conduct*

[8] "One who by extreme and outrageous conduct intentionally or recklessly causes severe emotional distress to another is subject to liability for such emotional distress. . ." *Rugg v. McCarty*, 173 Colo. 170, 476 P.2d 753, 756 (1970) (quoting Restatement (Second) of Torts §46(1) (1965). However:

> Liability has been found only where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community. Generally, the case is one in which the recitation of the facts to an average member of the community would arouse his resentment against the actor, and lead him to exclaim, "Outrageous!"

Id. (quoting Restatement (Second) of Torts §46 cmt. d).

It is for the trial court to determine, in the first instance, whether the conduct could be regarded as sufficiently atrocious to permit recovery. *Therrien v. United Air Lines, Inc.*, 670 F.Supp. 1517, 1524 (D.Colo. 1987); *First Nat'l Bank v. Collins*, 44 Colo. App. 228, 616 P.2d 154 (1980). I conclude as a matter of law that defendants' conduct in this case is not sufficiently outrageous to permit recovery. Accordingly, defendants are entitled to summary judgment on this claim.

E. *Negligent Misrepresentation*

[9] Buell's claim for negligent misrepresentation is that defendants, in this policy, negligently misrepresented that she would be entitled to coverage as set forth in the policy. This claim is not cognizable. *Scott Co. v. MK Ferguson Co.*, No. 90CA1100, 1991 WL 242922, at *5, -- P.2d --, -- (Colo.App. Nov. 21, 1991) ("the court erred in allowing the [negligence and negligent misrepresentation] claims to go to the jury since no duties independent of contractual duties were alleged to have been breached "); *see Jardel Enters., Inc. v. Triconsultants, Inc.*, 770 P.2d 1301, 1303 (Colo.App. 1988). Moreover, the claim also fails because Buell has received continuous payment for her medical expenses as provided in the contract.

F. *Exemplary Damages*

Because Buell is not entitled to any damages, she is not entitled to exemplary damages.

Accordingly, it is ORDERED that:

(1) a judgment shall issue declaring that Security General Life Insurance Company is obligated to provide Buell with coverage under Master Group Policy Number G-83255 for expenses incurred as a result of Buell's lung cancer with Buell not required to make future premium payments;

(2) defendants' motion for summary judgment on plaintiffs claims for breach of contract, breach of implied covenant of good faith and fair dealing, negligent misrepresentation, outrageous conduct, and punitive damages is GRANTED, and those claims are DISMISSED WITH PREJUDICE; and

(3) final judgment shall enter with Buell awarded her costs.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 91-B-868

PATTY L. BUELL,

Plaintiff,

v.

SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation, et al.,

Defendants.

PLAINTIFF'S MOTION TO RECONSIDER THE ORDER GRANTING SUMMARY JUDGMENT IN FAVOR OF DEFENDANT ON ALL ISSUES, OR IN THE ALTERNATIVE, FOR LEAVE TO FILE A SUPPLEMENTAL BRIEF IN REPLY TO DEFENDANTS' RESPONSE TO PLAINTIFF'S DECEMBER 2, 1991 BRIEF with SUPPORTING AFFIDAVIT OF PATTY L. BUELL and with MEMORANDUM AUTHORITY INCORPORATED HEREIN

Plaintiff, Patricia L. Buell, by her attorneys, JOHN A. CIMINO, P.C., for her Motion to Reconsider the Order Granting Summary Judgment in Favor of Defendant on all Issues, pursuant to Local Rule 605(C), or in the alternative, for Leave to File a Supplement Brief in Reply to Defendants' Response to Plaintiff's November 13, 1991 Brief, pursuant to Local Rule 402, states as follows:

1. On December 5, 1991, this Honorable Court indicated that it would be entering judgment in favor of the Defendants' on their Motion for Summary Judgment regarding Plaintiff's claims for

breach of contract, outrageous conduct, bad faith, and negligent misrepresentation. The Court has not yet issued its Order and therefore the undersigned has not yet reviewed it. This Motion nevertheless is being filed promptly in the event that if the Court does reconsider its Order that will be entered, that the December 16, 1991 trial date can be maintained.

2. In support therefor, Plaintiff states that Defendants have negligently misrepresented material facts to her and continue to act in bad faith. Furthermore, Plaintiff has been damaged as a result of the Defendants' conduct. Moreover, Plaintiff's experts have raised factual issues about the reasonableness of Defendants' cancellation practice, therefore summary judgment is precluded. See Roberts v. May, 41 Colo.App. 82, 583 P.2d 305 (1978); Camacho v. Honda Motor Co., Ltd., 741 P.2d 1240 (Colo.1987), cert. dismissed, _____U.S._____, 108 S.Ct. 1067, 99 L.Ed.2d 229 (1988).

3. Defendants purported rationale in terminating Plaintiff's insurance was because of the losses it was sustaining. See Defendants' May 19, 1990 letter to Mrs. Buell at page two, attached hereto as Exhibit "1". The Defendants defended this action by stating that:

> "This non-renewal action will be affecting all policies issued on this form, with the same type and level of benefits as yours. The decision to non-renew was not based on the individual claims of any one person such as yourself, but rather it was based on the claims experience of certificates similar to yours."

4. Thus, Defendants represented to Plaintiff in its May 19, 1990 letter to her that it was sustaining losses. Plaintiff requested in her First Combined Set of Interrogatories and Request for Production of Documents at Request for Production of Documents Number 22 that Defendants: "Provide Copies of all loss reserve documents". In its initial responses dated May 31, 1991, attached as Exhibit "2", Defendants refused to produce any

documents claiming confidentiality. It did respond to Interrogatory Number 1, stating that Plaintiff was covered by "Master Group Policy Number G-82355". When Defendants finally did respond to Request for Production Number 22 on August 26, 1991 (see Exhibit "3" attached hereto), they only provided summary figures for 1987, 1988, 1989 and 1990. Defendants concluded that the loss ratio was 98%. It was this figure that Defendants' expert used in concluding that it was reasonable for Defendants to base its termination upon since this loss was not acceptable. See Lautzenheiser deposition at p. 155-54, attached as Exhibit "4".

5. Mrs. Buell's coverage began in 1984. The undersigned repeatedly demanded all loss ratio data for all years. Finally, the Defendants did provide data for periods March, 1986 to 1990 and for all blocks of business after the Plaintiff filed a Motion to Compel and agreed to execute a Confidentiality Agreement. Plaintiff's counsel signed this Agreement under pressure since the deposition of Defendants' representative Peter Weaver was scheduled on November 14, 1991 in Phoenix, Arizona. In any event, the undersigned did sign the Confidentiality Agreement and on or about November 13, 1991, did receive the detailed loss ratio data for years March, 1986 to 1990. Still, no data for 1984 or 1985 was disclosed by Defendants.

6. The data received indicated that Defendants' loss ratio did not approach 98%. For example, Defendants suggested that the loss ratio for 1987 in Exhibit "3" was 91.70%. In truth, the actual loss ratio for this year was 80%. See Exhibit "5" attached hereto (page A00083). Actually, the loss ratio for this year was as low as 74.27%. See Exhibit "5", line highlighted in blue. Furthermore, it is possible that the 1987 loss ratio was as low as 60% for 1987. See Exhibit "6" attached hereto (page A00108).

7. Still not having received the data for 1984 and 1985, Plaintiff's counsel, to the best of his recollection, contacted Mr. Tim Walker, attorney for American Life and Casualty, of Des Moine, Iowa, by telephone on November 25, 1991, demanding data for 1984

and 1985. Mr. Walker indicated that Mr. Plissey already had this data and that he would only release it with Mr. Plissey's permission. It is unclear how long Mr. Plissey had this data. In any event, finally on November 26, 1991, the undersigned obtained loss ratio data for years 1984 and 1985. (Attached hereto as Exhibit "7").

8. Fairly confident that all the loss reserve data was disclosed, Plaintiff asked her expert, Joan Ogden, to calculate the loss ratios for the period 1984 to 1990. This was done by her for the first time on December 4, 1991. Attached hereto as Exhibit "8" is Ms. Ogden's analysis wherein she calculates that the loss ratio is 69%.

9. Ms. Ogden's figures appear to be the most accurate. Indeed, and quite by accident, Plaintiff's counsel very recently obtained a Report of Examination for Security General Life Insurance for period ending December 31, 1989 that was filed with the Colorado Division of Insurance on or about October 22, 1991. It is attached as Exhibit "9". At page 28 therein, the loss ratio for 1987 is 66.3%, not to mention that it is far short of 98% as claimed by Defendants for the same period of time.

10. The bottom line is that the Defendant, Security General Life Insurance, is not sustaining losses as it represented in its May 19, 1990 letter to Ms. Buell.

11. Even Defendants' expert Barbara J. Lautzenheiser ignores the bulk of the data. At pages 186-88 of her deposition (attached as Exhibit "9") she states that she never received data for 1984 and 1985 (deposition Exhibit No. 53, referred to herein as Exhibit "7"). Apparently she did receive the Confidential data (depo. at 187) but she chose not to analyze it. See Lautzenheiser depo. at 188.

12. Loss ratio data must be compiled on a durational basis. In other words, to obtain the most reliable indication of loss, one must add the incurred claims for the period in question and divide it by the earned premiums for the same period. See

Lautzenheiser depo. at pp. 150-53. It cannot be done by averaging the loss ratios for each year or using partial data. Therefore, Ms. Ogden's analysis as exemplified by Exhibit "8" is the most accurate and reveals that Defendant Security General is not experiencing a loss as claimed in its termination letter of May 19, 1990.

13. In Halter v. Waco Scaffolding & Equip. Co., 797 P.2d 790 (Colo.App. 1990), it was held that the Court abused its discretion in refusing to reconsider and vacate partial summary judgment in favor of one of several defendants where, following defendant's belated production of a key document, an issue as to a material fact arose. Here, Defendant has misrepresented the basis for its termination action by providing incomplete data, partial data or simply waiting to the last minute to provide data to prevent Plaintiff from correctly analyzing it.

14. Gerald Peters indicated in his Expert Witness Report that it was unreasonable for an insurance company to terminate coverage based upon a loss ratio of 98%. See Exhibit "9" attached hereto. It is only that much more egregious for an insurance company to terminate when its loss ratio is 69%.

15. The Defendants in their belated production of documents have profited. Halter recognized this problem and resolved it by determining that summary judgment should not have been entered since the case had not been fully adjudicated.

16. The Defendants argue that Mrs. Buell has not been damaged since they have paid and continue to pay her benefits. This is not true. Mrs. Buell's credit has been tarnished. See Mrs. Buell's Credit Report which is attached as Exhibit "10" hereto). Mrs. Buell has been the subject of repeated collection agency abuse. See Exhibit "11" attached hereto. On December 5, 1991, Mrs. Buell received two collection calls from collection agencies. See Buell affidavit attached as Exhibit "12". Finally, Mrs. Buell has personally paid over $2,000 in medical bills out of her own pocket this year to keep creditors at bay. See Buell affidavit.

17. Both Thomas Roberts, Plaintiff's legal expert, and Gerald Peters, Plaintiff's other actuary expert, question the reasonableness of Defendants' conduct. Mr. Roberts is of the opinion that it was unreasonable for Defendants to act without obtaining legal counsel prior to instituting the non-renewal action. See Roberts deposition at p. _____ attached as Exhibit "13". Mr. Peters is of the opinion that it is unreasonable for an insurance company to terminate coverage where loss ratios are 98%, let alone 69%. See Peters deposition at p. _____ attached as Exhibit "14".

18. It has been stated that where an expert witness raises a factual issue, summary judgment is precluded. Camacho, supra. In this case, two experts (not to mention Ms. Ogden) raise factual questions as to the reasonableness of Defendants' conduct. Hence, summary judgment cannot be granted in favor of the Defendants.

19. Defendants argue that it is only relevant that 53 certificateholders were nonrenewed. The entire block of business at issue is represented by the chart attached as Exhibit "15". It is still unclear whether all policy form numbers were canceled or only the piece of the pie where Mrs. Buell fell. Based upon the Defendants discovery responses and letters attached to it Motion to Reconsider, it would appear that only Mrs. Buell's small group (G-83255) was non-renewed, not the entire block which is described as "G-82240" at the top of the form.

WHEREFORE, it is respectfully requested that this Honorable Court will enter an Order reconsidering its Order granting Summary Judgment in favor of Defendant and permit this matter to be tried to a jury on December 16, 1991.

DATED this 6th day of December, 1991.

JOHN A. CIMINO, P.C.

/s/John A. Cimino

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1900 Grant Street, # 1100
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ATTORNEY FOR PLAINTIFF

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

PATRICIA L. BUELL,	)	
	)	Case No. 91-B-868
Plaintiff,	)	
	)	
v.	)	
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation, et al.,	)	
	)	
Defendants.	)	

MEMORANDUM OPINION AND ORDER

In a published Memorandum Opinion and Order dated December 6, 1991, 1573 F.Supp. 779, I granted plaintiff Patricia L. Buell's motion for summary judgment on her declaratory judgment claim and granted defendants' motion for summary judgment on Buell's damage claims. Final judgment was entered accordingly. Before me is Buell's motion to reconsider the order granting defendants' summary judgment motion. This motion is denied.

[1] Because judgment has entered, I consider Buell's motion as one for relief from judgment under Federal Rule of Civil Procedure 60(b). Rule 60(b) provides in pertinent part: "On motion and upon such terms as are just, the court may relieve a party or a party's legal representative from a final judgment, order, or proceeding for the following reasons: (1) mistake, inadvertence, surprise, or excusable neglect." Attached to her motion, Buell has submitted eighteen exhibits which she claims show

that there are genuine issues of material fact that preclude summary judgment. It was inexcusable neglect not to present these exhibits before summary judgment was granted.

Buell has terminal lung cancer. On her request, I put this case on a "fast track," setting trial less than seven months after the case was removed to this court. In response to defendants' motion for summary judgment, Buell protested that discovery was not yet complete. Accordingly, by order dated November 13, 1991, I gave the parties through December 2, 1991 to file additional summary judgment materials. Also on November 13, 1991, Buell received information from defendants on their "loss ratio" concerning her group insurance policy for 1986 to 1990. On November 26, 1991, she received information from defendants on their "loss ratio" for 1985 and 1986.

Buell now submits this loss ratio evidence as the primary basis for her motion to reconsider. If Buell considered this information material to her motion for summary judgment, she should have submitted it by December 2, 1991, as required by my previous order. Buell complains that her expert did not interpret this information until December 4, 1991. If that was the case, she should have filed a Rule 56(f) affidavit explaining why she could not" for reasons stated present by affidavit facts essential to justify the party's opposition." It was inexcusable neglect for Buell to wait until the cross motions for summary judgment had been ruled upon before submitting the evidence or before notifying the court that she had needed additional time to respond to defendants' motion.

Moreover, even if I consider the "new" evidence concerning loss ratio, it is immaterial. The evidence shows the loss ratio sustained by defendants on Buell's group insurance policy. In addition, Buell has submitted an expert's opinion that it was unreasonable for defendants to terminate the group policy based on this loss ratio. Buell claims that this evidence supports her breach of implied covenant of good faith and fair dealing claim, asserting two theories that allegedly justify recovery.

[2] Buell's first theory is that, based on expert witness opinions, it was unreasonable to terminate her group policy based the loss ratio sustained by defendants. However, provided that the decision to terminate is not based "solely on the grounds of the deterioration of the health of the Insured [Buell]," the policy allows for termination or for any reason whatsoever. Buell attempts to amend this termination provision to allow for termination only when the insurer is losing a sufficient amount of money, with the sufficiency being determined, in part, by plaintiff's experts. The implied covenant of good faith and fair dealing does not reach so far.

[3] Rather, "absent statutory enactment, there is no duty imposed upon insurers to renew their policies." *Armstrong v. Safeco Ins. Co.*, 111 Wash.2d 784, 765 P.2d 276, 278 (1988); *see* 18 George J. Couch, *Cyclopedia of Insurance Law* §68.12 (2d rev.ed. 1983). Buell asserts no Colorado statutory duty requiring renewal under the circumstances here. Hence, she may not defeat her insurer's contractual right to terminate by asserting that the reason for the termination is unreasonable. *See Gautreau v. Southern Farm Bureau Cas. Ins. Co.*, 429 So.2d 866 (La.1983), *rev'g*, 410 So.2d 815 (La.App.1982); *Coira v. Florida Medical Ass'n, Inc.*, 429 So.2d 23 (Fla.App. 1983); *cf. Gilmore v. Ute City Mortgage Co.*, 660 F.Supp. 437, 440 (D.Colo. 1986) ("I cannot rewrite an unambiguous termination clause so as to impose an extrinsic condition upon its exercise"). Accordingly, Buell's first theory fails as a matter of law.

[4] Buell's second theory is that the reason given to her why the policy was terminated was not truthful. I note that Buell is not seeking damages for injuries incurred in reliance on the alleged misrepresentation. Instead, she seeks damages resulting from the termination itself.

Assuming that this is a valid theory, Buell's tendered evidence is insufficient to support relief from judgment. Buell's theory is based on Security General's statement to her that "the

decision to nonrenew was not based on the individual claims of any one person such as yourself, but rather it was based on the claims experience of certificates similar to yours." Accordingly, to sustain relief from the grant of summary judgment, Buell would have to come forward with sufficient evidence from which a jury could conclude that the decision to terminate was not based on the claims experience of group policyholders. Buell fails to meet this burden.

Indeed, the evidence is uncontroverted that the decision to terminate was based on collective claims experience of group policyholders. Buell contends that there is a factual dispute as to how poor the claims experience actually was. This dispute is immaterial because the evidence remains uncontroverted that, whether deemed "poor" or merely "not good enough," the *claims experience* of the entire group of insureds formed the basis of the decision to terminate the group policy. Accordingly, Buell's second theory also fails as a matter of law.

Buell has also submitted exhibits relating to issues other than defendants' loss ratio. Because these exhibits should have been submitted before my ruling on the cross motions for summary judgment, I will not consider them now.

Accordingly, it is ORDERED that Buell's motion to reconsider is DENIED.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

PATRICIA L. BUELL,	)	
	)	Case No. 91-B-868
Plaintiff,	)	
	)	
v.	)	
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation, et al.,	)	
	)	
Defendants.	)	

MEMORANDUM OPINION AND ORDER

I. INTRODUCTION

On December 6, 1991, I granted plaintiff Patricia L. Buell (Buell)'s motion for summary judgment on her declaratory judgment claim and granted defendants' motions for summary judgment on Buell's damage claims. Final judgment was entered accordingly. On December 6, 1991 Buell filed a motion to reconsider. Before me now are Buell's December 16, 1991 motions to accept her motion to reconsider as one to alter or amend the judgment under Fed.R.Civ.P. 59(e), and to review taxation of costs under Fed.R.Civ.P. 54(d). I will treat her motion to reconsider as a motion to alter or amend the judgment under Rule 59(e), but I decline to alter or amend the judgment. Also, I deny her motion to review taxation of costs. Jurisdiction exists over this diversity case under 28 U.S.C. §1332 (1988).

II. MOTION TO ALTER OR AMEND THE JUDGMENT UNDER RULE 59(e)

[1] Because Buell's motion to reconsider was filed within ten days after the judgment, I accept it as one to alter or amend the judgment under Fed.R.Civ.P. 59(e). *Dalton v. First Interstate Bank of Denver*, 863 F.2d 702, 703 (10th Cir.1988). Both parties previously filed notices of appeal. Although a notice of appeal generally divests a district court of jurisdiction over a case, jurisdiction still exists here because a notice of appeal filed before disposition of a motion to alter or amend the judgment has no effect. *Wagoner v. Wagoner*, 938 F.2d 1120, 1122 (10th Cir.1991); Fed.R.App.P. 4(a)(4).

Since 1984 Buell held a certificate of insurance in a group health insurance policy offered by defendants. In 1985 Security General Life Insurance Company (Security General) purchased the rights and insurance lability risks represented by this policy. Consequently, it is the only defendant liable on Buell;s claim and, thus, the only defendant responding to this motion.

In 1986 Buell developed lung cancer. In May, 1990 Security General informed Buell that it would not renew her certificate of insurance as of June 19, 1990 because of poor claims experience with the group insurance policy. Buell then sued defendants for declaration of continued coverage under her certificate and, *inter alia,* breach of covenant of good faith and fair dealing.

In response to Security General's summary judgment motion, Buell protested that discovery was not yet complete. Accordingly, by an order dated November 13, 1991, I gave the parties through December 2, 1991 to file additional summary judgment materials. By November 26, 1991, Buell received certain "loss ratio" information from defendants disclosing the losses sustained by them on the group insurance policy from 1984 through 1990. However, Buell now argues that this information was not included in her summary judgment response because Security General's delay in providing her with this information delayed her

expert's analysis of this information until December 4, 1991.

On December 6, 1991 I granted summary judgment for Buell on her declaratory judgment claim, holding that Security General is liable for Buell's expenses incurred after expiration of the policy, because the insurance policy was an "injury" policy. *Buell v. Security General Life Ins. Co.*, 779 F.Supp. 1573 (D.Colo.1991). I also granted summary judgment for Security General on Buell's damage claims because it continued to provide her with the benefits of the insurance policy, although it disputed that it was liable to pay for expenses incurred after the policy expired. *Id.*

In her motion to alter or amend the judgment, Buell submits the loss ratio evidence, claiming that it proves that Security General was not losing money on this policy. Security General maintained that it refused to renew the group policy because of large loss ratios. Thus, Buell contends that this loss ratio evidence creates a genuine issue as to Security General's reasonableness in refusing to renew her insurance. Because of this fact dispute, she maintains that summary judgment should not have been entered on her claim for breach of covenant of good faith and fair dealing.

[2,3] Under Rule 59(e), a judgment can be altered or amended to correct manifest errors of fact or law, or accept newly discovered evidence. *FDIC v. Meyer*, 781 F.2d 1260, 1268 (7th Cir. 1986). Rule 59(e) motions, however, are directed at reconsideration, not initial consideration. *Building & Const. Trades Dept. v. Rockwell International*, 758 F.Supp. 1428, 1429 (D.Colo. 1991). A party cannot invoke Rule 59(e) to raise arguments or evidence that could and should have been presented during the summary judgment process. *Id.; Evans v. County Commissioners of Boulder County*, 752 F.Supp. 973, 978 (D.Colo.1990).

[4] There is considerable confusion among the circuits concerning the standards that guide a district court's exercise of discretion in determining whether to reopen a case based on a Rule 59(e) motion advancing new evidence. *See Lavespere v.*

Niagara Mach. & Tool Works, Inc., 910 F.2d 167, 172 (5th Cir.1990). The Tenth Circuit has not spoken on this subject. Some courts hold that a district court has no discretion to consider additional evidence after final judgment, unless the evidence is newly discovered, under Fed. R.Civ.P. 60(b) standards. *Boryan v. United States*, 884 F.2d 767, 771 (4th Cir.1989). *See also Lavespere*, 910 F.2d at 172 n. 3. Others hold that the materials can be considered if the failure to submit the evidence timely was "excusable neglect". *See Lavespere*, 910 F.2d at 172 n. 4. Still others rule that the omitted evidence will be considered if there is some plausible explanation for its earlier absence, or if accepting the evidence will not unduly prejudice the other party. *See Lavespere*, 910 F.2d at 172-173 nn. 5-6. *Lavespere* rejected these approaches and held that a court should consider, among other things, the reasons for the moving party's default, the importance of the omitted evidence to the moving party's case, whether the evidence was available to the nonmovant before responding to the summary judgment motion, and the likelihood that the nonmoving party will suffer unfair prejudice if the case is reopened. *Lavespere*, 910 F.2d at 174.

I apply the *Lavespere* Approach because it strikes a proper balance between the need to conclude litigation and the need to render just decisions on the basis of all the facts. Under this analysis, however, this case will not be reopened to consider Buell's "new evidence".

[5] First, the evidence is not "new". Buell's excuse that she did not receive the loss ratio information from Security General until November 26, 1991 does not justify its absence from her summary judgment response. She had this evidence before the summary judgment briefing schedule ended. In a December 11, 1991 order, I held that it was inexcusable neglect to wait until after I ruled on the summary judgment motions to submit this evidence. *Buell v. Security General Life Insurance Co.*, 779 F.Supp. 1579 (D.Colo.1991). At a minimum she could have sought Rule 56(f) relief to obtain a reasonable extension of time to prepare and submit her expert report. Second, as explained below, this

evidence is not material to Buell's bad faith claim. Finally, although Security General would not suffer unfair prejudice if this case is reopened, this factor alone is insufficient to reopen the case and consider this evidence. The immateriality of this evidence, combined with Buell's failure to explain sufficiently her reason for omitting it, warrants denial of her Rule 59(e) motion. Consequently, I will not consider this evidence.

[6] Even if considered, however, this new evidence is immaterial. An insurer does not have to renew a policy unless obligated by statute or contract to do so. *Armstrong v. Safeco Ins. Co.*, 111 Wash.2d 784, 790, 765 P.2d 276, 279 (1988). *See also* 18 George J. Couch, *Cyclopedia of Insurance Law* §68.12 (2d rev. ed. 1983). Buell asserts no contractual or statutory duty requiring renewal under the circumstances of this case. Hence, because Security General had no duty to renew the group policy, evidence tending to show that Security General was unreasonable in refusing to renew it is meaningless and, thus, immaterial under Rule 56. *See Gautreau v. Southern Farm Bureau Cas. Ins. Co.*, 429 So.2d 866 (La.1983); *Coira v. Florida Medical Ass'n, Inc.*, 429 So.2d 23 (Fla.App.1983). Therefore, I will not alter or amend the judgment based on this immaterial evidence.

Buell also contends that I should alter or amend the judgment because I decided this case without the benefit of *Martin v. Principal Casualty Insurance Co.*, 15 Brief Times Reporter 1697 (Colo.App.1991). Buell contends that *Martin* rejects the notion that a bad faith claim is limited to denials of insurance coverage. *Martin*, 15 Brief Times Reporter at 1699. Rather, Buell argues that actionable bad faith can occur at any time during the course of conduct between the parties. *Martin*, 15 Brief Times Report at 1699.

In her summary judgment response, Buell specified four theories supporting her bad faith claim: (1) insufficient notice of termination of her insurance; (2) termination of her certificate because of her deteriorating health; (3) being singled out when her

certificate was terminated; and (4) requiring her to fill out a claim form every three months. I concluded that these theories were insufficient as a matter of law to support her bad faith claim. Specifically, in rejecting her fourth theory, I stated that I am aware of no Colorado court holding an insurer liable for the tort of bad faith where it required an insured to fill out a claim form every three months.

Arguably, *Martin* subjects this conduct to bad faith scrutiny because bad faith can arise at any time during the course of conduct between the parties. *See Martin,* 15 Brief Times Reporter at 1699. *Martin* is inconsequential here, however, because I also concluded that no reasonable jury could find that Security General's conduct was unreasonable. If anything *Martin* reinforces this conclusion because it recognizes that:

> To recover for bad faith breach of an insurance contract, one must prove that the insurer's conduct, viewed objectively in light of standards of conduct in the industry, was unreasonable and that the insurer either knew that its conduct was unreasonable or recklessly disregarded the fact that its conduct was unreasonable. (citation omitted).

Martin, 15 Brief Times Reporter at 1699.

Thus, the four theories advanced by Buell to support her bad faith claim are insufficient as a matter of law because no reasonable jury could conclude that, viewed objectively in light of the industry's standards of conduct, Security General acted unreasonably here. Accordingly, Buell's motion to alter or amend the judgment is denied.

III. MOTION TO REVIEW TAXATION OF COSTS UNDER RULE 54(d)

On December 20, 1991, the chief deputy clerk of this court taxed costs against Security General pursuant to Fed.R.Civ.P.

54(d). In her timely motion to review this taxation of costs, Buell contends that she is entitled to attorney and expert witness fees. Earlier, Buell had moved to amend the judgment, seeking attorney fees, arguing that equity and Colorado's Declaratory Judgment Act require an award of attorney fees. I denied this motion. *Buell v. Security General Life Insurance Co.*, No. 91-B-868 (D. Colo.January 9, 1992). Thus, I will not reexamine these same arguments repeated here.

[7] Relying on *Fleischmann Distilling Corp. v. Maier Brewing Co.*, 386 U.S. 714, 87 S.Ct. 1404, 18 L.Ed.2d 475 (1967) and *Agee v. Trustees of Pension Board*, 33 Colo.App. 268, 518 P.2d 301 (1974), Buell now contends that the common fund doctrine supports an award of expert witness and attorney fees. Under this doctrine attorney fees are awarded to a prevailing party out of an identifiable, common fund so that similarly situated parties who are not formal parties to the action share the costs of a litigation from which they will benefit because of the case's *stare decisis* effect. *See Sprague v. Ticonic National Bank*, 307 U.S. 161, 166, 59 S.Ct. 777, 779, 83 L.Ed. 1184, 1187 (1939). This case involves neither a common fund nor demonstrably similarly situated parties who will benefit from the *stare decisis* effect of this decision. Hence, I decline to award expert witness and attorney fees under the common fund doctrine.

Finally, I decline to award expert witness and attorney fees as a sanction against Security General.

Accordingly, it is ORDERED that Buell's motion to accept her motion to reconsider as one to alter or amend the judgment under Rule 59(e) is GRANTED, but her motion to alter or amend the judgment is DENIED. Also, her motion to review taxation of costs is DENIED.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

PATRICIA L. BUELL,	)	
	)	Nos. 92-1038 &
Plaintiff-Appellee,	)	92-1063
v.	)	
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation,	)	
	)	
Defendant-Appellant,	)	
	)	
and	)	
	)	
AMERICAN LIFE AND CASUALTY INSURANCE COMPANY, an Iowa corporation, et al.,	)	
	)	
Defendants.	)	

PATRICIA L. BUELL,	)	
	)	
Plaintiff-Appellant,	)	Nos. 92-1040 &
v.	)	92-1058
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation; et al.	)	
	)	
Defendants-Appellees.	)	

APPEAL FROM THE U. S. DISTRICT COURT
FOR THE DISTRICT OF COLORADO
(D.C. No. 91-B-868)

Submitted on the briefs:

John A. Cimino, P.C., Denver, Colorado, for Plaintiff-Appellant.

Michael A. Williams and Steven D. Plissey, of Williams, Youle & Koenigs, P.C., Denver, Colorado, and Thomas M. Herlihy, of Kelly Herlihy & Bane, San Francisco, California, for Defendants-Appellees.

Before TACHA and BALDOCK, Circuit Judges, and BROWN, ** Senior District Judge.

**Honorable Wesley E. Brown, Senior District Judge, United States District Court for the District of Kansas, sitting by designation.

TACHA, Circuit Judge.

Patricia Buell, the plaintiff in the district court, brought suit against her health insurance provider, Security General Life Insurance Co., seeking a declaratory judgment that she is covered under her policy and seeking damages for breach of contract, breach of implied covenant of good faith and fair dealing, negligent misrepresentation, and outrageous conduct. The district court entered a declaratory judgment against defendant-

appellant/cross-appellee Security General finding that the policy at issue was ambiguous and should therefore be construed in favor of coverage for plaintiff. Memorandum Opinion and Order at 1-2, Appellant's App., Vol. II at B432-33. Defendant appeals from this judgment. The court further held that, because defendant had continued to provide benefits to plaintiff during the course of the litigation, there had been no breach of contract, and that plaintiff had failed to demonstrate the presence of issues of material fact regarding her claims of breach of the implied covenant of good faith and fair dealing, negligent misrepresentation, and outrageous conduct. Id. at B433. Plaintiff appeals the district court's grant of summary judgment to defendant on those issues, as well as the district court's refusal to consider her additional evidence offered pursuant to Fed. R. Civ. P. 59(e).[1]

In 1983, American Life and Casualty Insurance Company (American Life) delivered to Consumer Health Care Association (CHCA) a group health insurance policy. In 1984, plaintiff was issued a Certificate of Group Insurance as evidence of the insurance provided under the policy. Defendant Security General later purchased from American Life the rights and insurance liability risks represented by the policy.

In 1986, plaintiff was diagnosed with lung cancer, and in 1990, defendant terminated the group policy. Plaintiff brought a declaratory judgment action arguing that her benefits should continue despite this termination. The district court correctly concluded that, with regard to the coverage issue, the determining factor was whether the policy is one for "expenses" or one for "injury." Id. at B436. If the policy is one for expenses, defendant is liable for medical and hospital related expenses as those expenses are incurred, and plaintiff loses the right to benefits when the policy terminates.

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[1] After examining the briefs and appellate record, this panel has determined unanimously that oral argument would not materially assist the determination of this appeal. See Fed. R. App. P. 34(a); 10th Cir. R. 34.1.9. The case is therefore ordered submitted without oral argument.

Lister v. American United Life Ins. Co., 797 P.2d 832, 834 (Colo. Ct. App. 1990). Alternatively, if the policy is an "injury" policy, it covers expenses arising from a covered injury if that injury occurs while the policy is in force. See Loesekan v. Benefit Trust Life Ins. Co., 552 P.2d 36, 37 (Colo. Ct. App. 1976). Under an "injury" policy, expense arising out of a covered injury which occurred while the policy was in force are paid even if the policy has terminated.

"An insurance policy is a contract which should be interpreted consistently with the well settled principles of contractual interpretation." Chacon v. American Family Mut. Ins. Co., 788 P.2d 748, 750 (Colo. 1990). "Interpretation of a written contract is generally a question of law for the court subject to independent reevaluation by an appellate court." Underdown v. Kissell, 817 P.2d 617, 618-19 (Colo. Ct. App. 1991).

> Whether the terms of a contract are ambiguous is a matter of law for the court to decide. To ascertain whether contract provisions are ambiguous, language must be construed according to the plain and generally accepted meaning of the words used, and reference must be made to all provisions of the agreement. A difference of opinion regarding the interpretation of an instrument does not, by itself, create an ambiguity.

Zimmerman Metals, Inc. v. United Eng'rs & Constructors, Inc., Sterns-Roger Div., 720 F. Supp. 859, 860 (D. Colo. 1989) (construing Colorado law) (citations omitted). "Extrinsic evidence and presumptive rules in aid of construction may be used only if the instrument itself is ambiguous, unclear, or uncertain as to the meaning the parties intended by it." Barnes v. Van Schaack Mortgage, a Div. of Van Schaack & Co., 787 P.2d 207, 209 (Colo. Ct. App. 1990). Because the district court here considered the policy to be ambiguous, it went beyond the policy language and read the policy in conjunction with Colorado statutory law. The court also construed the policy in favor of the insured. See Chacon, 788 P.2d at 750.

The policy provides:

> When as a result of sickness or accidental bodily injury, an Insured Person incurs Covered Expenses shown herein while this insurance is in force as to such Person, the Company will pay the applicable percentage, shown in the Policy Specifications, of such expenses incurred in excess of the Deductible Amount, not to exceed the Maximum Amount.

Appellant's App., Vol. I at B074. Covered Expenses are defined as "the Usual and Customary charges for [specified] services, supplies and treatment when medically necessary and when ordered by a Physician and Surgeon . . . ." Id. at B075. The district court concluded that the policy could reasonably be construed as either an expense policy or an injury policy. We disagree and reverse the district court's declaratory judgment in favor of plaintiff.

Defendant correctly argues that the obligation to pay benefits under this policy is triggered only when an expense is incurred and not because an injury or illness has occurred during the life of the policy. Liability attaches only when the insured incurs "Covered Expenses . . . while this insurance is in force." "Covered Expenses," defined as the charges for supplies and service, do not accrue prospectively for an illness that may have occurred during the coverage period. It is only when the insured actually incurs expenses during the term of the policy that defendant is obligated to pay benefits. Because this policy provides coverage for expenses, as they are incurred, it is indistinguishable on that issue from the policy in Lister, and does not entitle plaintiff to post-termination benefits. See Lister, 797 P.2d at 834.

The district court identified no language in the policy which created an ambiguity, nor do we find any. Instead, the district court reasoned backwards from Colo. Rev. Stat. §10-8-

116(2)(b)(V) to conclude that this was an injury policy.[2] The court reasoned that, because the statute requires expense policies to contain a conversion privilege, and because this policy did not contain such a privilege, it, therefore, was not an expense policy.

We acknowledge that, by operation of law, Colorado insurance statutes are an implied part of policies governed by Colorado law. Crowley v. Hardman Bros., 223 P.2d 1045, 1050 (Colo.1950) ("legislation in force at the time of the issuance of the policy became part and parcel thereof as definitely as if written therein."). At the time this policy was written, however, section 10-8-116(3)(a), which specified the requirements of the conversion privilege, applied only to policies delivered or issued for delivery in Colorado. Colo. Rev. Stat. §10-8-116(3)(a)(Cum. Supp.1986). There was no evidence before the district court that the policy here was delivered or issued for delivery in Colorado. The policy was executed by American Life in Fargo, North Dakota, Appellant's App., Vol. I at B057, to a policyholder also located in Fargo. Id. at B058. While a certificate of insurance was delivered to plaintiff in Colorado, id. at B093, the delivery of a certificate is not tantamount to the delivery of a policy. New England Mut. Life Ins. Co. v. Gray, 786 F.2d 406, 408-09 (6th Cir. 1986) (Michigan law does not apply to a group annuity contract issued in Minnesota where the certificate was delivered to a beneficiary in Michigan.). Our conclusion that the statute here did not apply to plaintiff's policy is buttressed by the fact that section 10-8-116(2)(a) was later

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[2] That statute, in force at the time the policy was delivered, provided:

> If the group insurance policy provides hospital, surgical, or major medical insurance or any combination of these coverages on an expense-incurred basis, for other than specified diseases or accidental injuries only, it shall also contain a conversion privilege conforming to the requirements of subsection (3) of this section.

Colo. Rev. Stat. §10-8-116(2)(b)(V)(Cum. Supp. 1986). Subsection (3) of the above quoted section mandated a conversion privilege for all group policies "delivered or issued for delivery in this state." Colo. Rev. Stat. §10-8-116(3)(a)(Cum. Supp. 1986).

amended to apply to "all policies of group sickness and accident insurance providing coverage to persons residing in the state," Colo. Rev. Stat. §10-8-116(2)(a)(1987 Repl. Vol. Cum. Supp. 1991), suggesting that the scope of the earlier statute was more limited.

In addition to the absence of a conversion privilege, the district court also noted that, because the policy did not explain what happened upon termination, it could reasonably be construed as an injury policy. The court apparently read Lister, 797 P.2d 832, to require an extended benefits provision before a policy would be construed as an expense policy. We disagree with the district court's reading of Lister regarding the presence or absence of an extended benefits provision.

Lister construed a policy that happened to have an extended coverage section. Id. at 834. It does not stand for the proposition that every expense policy must have such a provision, and that, without one, the policy will be an injury policy. Lister turned on the fact that the policy covered expenses as they were incurred and thus precluded the finding of an injury policy. Id. at 834. Because we find that the district court erred in holding that this policy was ambiguous and should therefore be construed as an injury policy, we reverse the judgment of the district court in appeal No. 92-1038.

In addition to entering judgment for plaintiff on the coverage issue, the district court also granted summary judgment to defendant on plaintiff's claim of breach of contract and various tort claims. In so doing, the district court correctly acknowledged that Fed. R. Civ. P. 56(e) mandates the entry of summary judgment if there is no genuine dispute of material fact, and the moving party is entitled to judgment as a matter of law. We apply the same standard in conducting our de novo review as did the district court. Renfro v. City of Emporia, 948 F.2d 1529, 1533 (10th Cir. 1991), cert. dismissed, 112 S. Ct. 1310 (1992).

Our determination that defendant was not liable for plaintiff's benefits beyond the date of termination resolves plaintiff's

breach of contract claim based on failure to pay. We also agree with the district court that plaintiff failed to offer evidence of breach because of untimely notice of termination. And finally, we find no error in the district court's conclusion that the policy was not wrongfully terminated.

The policy provides that:

> The policy continues in effect from its effective date specified on the face of the policy as long as the premium is paid as provided herein, subject to the Grace Period as provided in the General Provisions hereof; provided however, that:
>
> . . . .
>
> B. The Company may terminate the policy on any premium due date by giving written notice to the Policyholder at least 31 days prior to any premium due date.
>
> C. The Company will not terminate or nonrenew the certificate solely on the grounds of the deterioration of the health of the Insured.

Appellant's App., Vol. I at B065. Plaintiff argues that by not renewing blocks of business that had poor claims experience, defendant violated the policy by terminating "solely on the grounds of the deterioration of the health of the Insured." This argument is without merit.

Based on policy language, defendant could terminate the policy for any reason or for no reason, except that it could not terminate "solely on the grounds of the deterioration of the health of the Insured." The parties do not dispute that the term "Insured" in paragraph C above refers to plaintiff. In order for plaintiff to prevail on her claim of wrongful termination, she would have to put forth evidence that defendant terminated the insurance plan because

she had contracted lung cancer. This plaintiff has failed to do. Defendant's evidence was that it was losing money on an entire block of group policies sold to CHCA and so decided to terminate several group policies. Appellant's App., Vol. I at B184. Plaintiff's evidence that defendant was not losing enough money to justify termination is irrelevant. As long as plaintiff has not shown that the group policy was canceled specifically because of her health problems, she has not shown that defendant wrongfully terminated the policy.

With regard to her claim for breach of the implied covenant of good faith and fair dealing, plaintiff argues that, even where an insurer is not liable for coverage, an insured can still recover extra-contractual damages for breach of the implied covenant. Plaintiff cites no Colorado case for this proposition, but that failure, in itself, does not doom plaintiff as much as the fact that plaintiff's evidence of bad faith does not rise to the level necessary to establish a genuine issue of material fact and to prevail as a matter of law.

> To recover for bad faith breach of an insurance contract, one must prove that the insurer's conduct, viewed objectively in light of standards of conduct in the industry, was unreasonable and that the insurer either knew that its conduct was unreasonable or recklessly disregarded the fact that its conduct was unreasonable.

Martin v. Principal Casualty Ins. Co., 835 P.2d 505, 510 (Colo. App. 1991) (citing Travelers Ins. Co. v. Savio, 706 P.2d 1258, 1274 (Colo. 1985)). The district court was correct in concluding that plaintiff's evidence failed to meet this standard.[3]

---

[3] Plaintiff's contention that her expert's testimony regarding violation of Colo. Rev. Stat. §10-3-1104(1)(h) created an issue of fact is mistaken. Even if an expert's testimony were to be admissible regarding the legal question of statutory violation, the testimony did not establish any material, factual issue here regarding defendant's conduct sufficient to

After the district court had entered summary judgment against plaintiff on her breach of contract and tort claims, plaintiff attempted to introduce what she characterized as "new" evidence by way of a motion under Fed. R. Civ. P. 59(e). [4] The district court noted that no Tenth Circuit law defined the standards for determining whether to reopen a case based on a Rule 59(e) motion advancing new evidence. After surveying other circuit law, the district court adopted the formula set out by the Fifth Circuit in Lavespere v. Niagara Mach. & Tool Works, Inc., 910 F.2d 167 (5th Cir. 1990), which counsels a district court to

> consider, among other things, the reasons for the moving party's default, the importance of the omitted evidence to the moving party's case, whether the evidence was available to the non-movant before she responded to the summary judgment motion, and the likelihood that the nonmoving party will suffer unfair prejudice if the case is reopened.

Id. at 174.

Since the district court's decision, however, this circuit has held in Committee for the First Amendment v. Campbell, 962 F.2d 1517, 1523 (10th Cir. 1992), that

> when supplementing a Rule 59(e) motion with additional evidence, the movant must show either that

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preclude summary judgment. See Appellant's App., Vol. I at B243-58.

[4] Rule 59(e) provides:

> (e) Motion to Alter or Amend a Judgment. A motion to alter or amend the judgment shall be served not later than 10 days after entry of the judgment.

> the evidence is newly discovered and if the evidence was available at the time of the decision being challenged, that counsel made a diligent yet unsuccessful effort to discover the evidence.

Id. (quoting Chery v. Bowman, 901 F.2d 1053, 1057-58 n.6 (11th Cir. 1990). A district court's ruling on a Rule 59(e) motion is reviewed for abuse of discretion. Id.

Regardless of which standard is used in considering her Rule 59(e) motion, plaintiff has not shown that her late-offered evidence should have been considered b the district court. Plaintiff's evidence consisted of an expert's opinion of loss/ratio data obtained from defendant. This evidence not only fails to meet either of the standards discussed above, it is irrelevant to the question of wrongful termination. As explained above, as long as defendant did not terminate because of the deterioration in plaintiff's health, it had the right to terminate at will. Evidence of loss/ration data to show that defendant's termination was for financial reasons, whether considered adequate by plaintiff's experts or not, was irrelevant. The district court did not abuse its discretion in refusing to consider it.

The judgment of the United States District Court for the District of Colorado is AFFIRMED with respect to the grant of summary judgment on plaintiff's damage claims and the denial of her Rule 59(e) motion. With respect to the issue of coverage, the judgment of the United States District Court for the District of Colorado is REVERSED and REMANDED for entry of a declaratory judgment in favor of defendant.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

PATRICIA L. BUELL,	)	
	)	Nos. 92-1038 &
Plaintiff-Appellee,	)	92-1063
v.	)	
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation,	)	
	)	
Defendant-Appellant,	)	
	)	
and	)	
	)	
AMERICAN LIFE AND CASUALTY INSURANCE COMPANY, an Iowa corporation, et al.,	)	
	)	
Defendants.	)	

PATRICIA L. BUELL,	)	
	)	
Plaintiff-Appellant,	)	Nos. 92-1040 &
v.	)	92-1058
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation; et al.	)	
	)	
Defendants-Appellees.	)	

PETITION FOR REHEARING PURSUANT TO F.R.A.P. 40
WITH SUGGESTION FOR REHEARING IN BANC

TO THE HONORABLE JUDGES OF THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT:

Petitioner, Patricia Buell, the Appellant and Appellee, respectfully suggests that the above entitled proceeding is appropriate for consideration by all the judges of this Court convened in banc, and in support of this suggestion, Petitioner shows:

1. The judgment below is of exceptional importance in that it conflicts with the majority of courts that have considered the question presented, namely, whether an insured can claim the benefits of a certificate of insurance delivered to her when she never received the policy. Here, this Court ruled that because there was no evidence that the policy was ever delivered or issued for delivery in Colorado, that Colorado law does not apply.

2. The majority of courts addressing this issue ignore the law of the place where the policy is delivered and enforce the provisions of the delivered certificate based on the law of the place of the delivery of the certificate or in this case, Colorado. See Blue Cross v. Chestnut Lodge, 567 A.2d 147, 150-51 (Md. App. 1989) which cites the numerous jurisdictions that follow this rule. See also Hale v. Life Ins. Co. of North America, 750 F.2d 547 (6th Cir. 1984); Krauss v. Manhattan Life Ins. Co. of New York, 700 F.2d 870 (2nd Cir. 1983); Davis v. Crown Life Ins. Co., 696 F.2d 1343 (11th Cir. 1983); Krauss v. Manhattan Life Ins. Co. of New York, 643 F.2d 90 (2nd Cir. 1981).

3. The Tenth Circuit has previously ruled that Colorado courts must employ the law of the state with the most significant relationship to the contract. Budd v. American Excess Ins. Co., 928 F.2d 344 (10th Cir. 1991). See also Oakley v. National Western Life Ins. Co., 294 F. Supp. 504, 508 (S.D.N.Y. 1968) (law of place of delivery of certificate applies to insurance dispute).

4. Colorado law governs the interpretation and legal effect of this dispute because insurance issues are peculiarly matter of local concern. Pink v. A.A.A. Highway Express, 62 S.Ct. 241, 314 U.S. 201, 86 L.Ed. 152 (1941). Furthermore, by delivering the certificate to Mrs. Buell in Colorado, Security General is subject to its laws. Clay v. Sun Insurance Office, Ltd., 84 S.Ct. 1197, 377 U.S. 179, 12 L.Ed.2d 229 (1964). It is respectfully submitted that the judgment which is the subject of this Petition turned upon law that represents the minority view.

5. Also, the decision conflicts with Colorado state law and other federal cases that hold that a bad faith tort accrues upon the insurer's refusal to pay benefits and that subsequent payment does not absolve the tort. See Farmers Group, Inc. v. Trimble, 691 P.2d 1138 (Colo.1984) citing Berry v. United of Omaha, 719 F. 2d 1127, 1229 (11th Cir.1983).

6. Petitioner submits that the District Court did not err when it applied Colorado law to this dispute. Petitioner however does believe that Colorado law should be applied to uphold her bad faith claim and that Security General's temporary payment of benefits following the commencement of Mrs. Buell's action does not relieve it of bad faith tort liability.

STATEMENT OF COUNSEL

I, JOHN A. CIMINO, P.C., express a belief, based on reasoned and studied professional judgment, that the panel decision is contrary to decisions of the United State Court of Appeals for the Tenth Circuit or the Supreme Court of the United States, and that consideration by the full Court is necessary to secure and maintain uniformity of decisions in this Court, to-wit, the panel's decision is contrary to the decision of this Court or the Supreme Court as stated herein and this appeal involves a question of exceptional importance as stated herein.

WHEREFORE, Petitioner respectfully requests:

1. That a rehearing of the appeal in the above-entitled cause be granted; and

2. That the Honorable Judges of this Court order that the above-entitled cause be heard by the court in banc.

Dated this 17th day of March, 1993.

JOHN A. CIMINO, P.C.

/s/ John A. Cimino
John A. Cimino, Reg. #14032
1900 Grant Street, Suite 1100
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(303) 830-7274

CERTIFICATE

As counsel for PATRICIA BUELL, I hereby certify that the foregoing Petition for rehearing is presented in good faith and not for delay.

/s/ John A. Cimino
John A. Cimino, P.C. #14032
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UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

PATRICIA L. BUELL,	)	
	)	Nos. 92-1038 &
Plaintiff-Appellee,	)	92-1063
v.	)	
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation,	)	
	)	
Defendant-Appellant,	)	
	)	
and	)	
	)	
AMERICAN LIFE AND CASUALTY INSURANCE COMPANY, an Iowa corporation, et al.,	)	
	)	
Defendants.	)	

PATRICIA L. BUELL,	)	
	)	
Plaintiff-Appellant,	)	Nos. 92-1040 &
v.	)	92-1058
	)	
SECURITY GENERAL LIFE INSURANCE COMPANY, an Oklahoma corporation; et al.	)	
	)	
Defendants-Appellees.	)	

ORDER

Before McKAY, Chief Judge, LOGAN, SEYMOUR, MOORE, ANDERSON, TACHA, BALDOCK, BRORBY, EBEL, and KELLY, Circuit Judges, and BROWN, ** Senior District Judge.

** Honorable Wesley E. Brown, Senior District Judge, United States District Court for the District of Kansas, sitting by designation.

This matter is before the court on Patricia Buell's petition for rehearing with suggestion for rehearing in banc.

The materials submitted by Ms. Buell have been reviewed by the members of the hearing panel, who conclude that the original disposition was correct. Accordingly, the petition is denied on the merits.

The petition having been denied on the merits by the panel to which the case was submitted, the suggestion for rehearing in banc was transmitted to all the judges of the court in regular active service in accordance with Rule 35(b) of the Federal Rules of Appellate Procedure. As no member of the hearing panel and no judge in regular active service on the court has requested that the court be polled on rehearing in banc pursuant to Rule 35, Federal Rules of Appellate Procedure, the suggestion for rehearing in banc is denied.

The application of Security General Life Insurance Company for costs in the amount of $353.20 is granted.

Entered for the Court

ROBERT L. HOECKER, Clerk
By: /s/Patrick Fisher
Patrick Fisher
Chief Deputy Clerk

Supreme Court, U.S.
FILED
SEP 16 1993
OFFICE OF THE CLERK

No. 93-262

In The

Supreme Court of the United States

October Term, 1993

PATRICIA L. BUELL,

Petitioner,

vs.

SECURITY GENERAL LIFE INSURANCE COMPANY,
An Oklahoma Corporation, et al.,

Respondents.

Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit

BRIEF IN OPPOSITION

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RESPONDENT'S STATEMENT OF THE CASE

Several aspects of petitioner's Statement of the Case require a response.

1. Petitioner's Statement of the Case is incomplete because it neglects to recite that following the termination of the policy, Security General Life Insurance Company ("Security General") continued to provide petitioner with benefits under the policy. The district court specifically found that petitioner received continuous policy benefits and that the insurance contract was never breached. (Pet. App. at A-7.) Despite the policy's termination, petitioner experienced no interruption in coverage.

2. Petitioner claims that respondent belatedly supplied discovery which her expert needed to form an opinion. (Pet. at 4.) No factual support is provided for this allegation and the courts below made no such finding. Security General denies that any discovery was belatedly supplied.

3. Petitioner presents legal argument in her Statement of the Case. (Pet. at 4-5.) Respondent addresses these matters in its argument below.

SUMMARY OF ARGUMENT

A. The inter-circuit conflicts claimed by petitioner do not exist.

B. Petitioner waived any application of an excusable neglect standard under Fed. R. Civ. P. 6(b) by specifically asking the district court to treat its motion to

reconsider under Fed. R. Civ. P. 59(e) and by not raising any issue regarding Rule 6(b) before the Tenth Circuit Court of Appeals ("Tenth Circuit"). In any event, Rule 59(e) provides the applicable standard because it deals with the specific procedural situation presented below. Finally, the evidence offered in the motion to reconsider was irrelevant.

C. There are no special or important reasons for this Court to review the Tenth Circuit's reading of an unambiguous state statute.

D. Although petitioner claims that the Tenth Circuit held that reinstatement of benefits moots a claim for bad faith breach, the court below made no such ruling. Certiorari should not issue to review a decision which was never made.

ARGUMENT

A. NO INTER-CIRCUIT CONFLICTS EXIST.

Petitioner asserts that each of her proposed issues for certiorari involve "inter-circuit conflicts." (Pet. at 8, 10, 12.) No conflicts exist. With only a single exception,[1]

[1] In her Statement of the Case, petitioner cites *Berry v. United of Omaha*, 719 F.2d 1127 (11th Cir. 1983). *Berry* held that an action for bad faith breach accrues when the insurer first refuses to pay a claim and that the insurer's eventual decision to make payment provides no defense. 719 F.2d at 1129. *Berry* creates no conflict. The Tenth Circuit below neither held nor implied that

petitioner does not even attempt to cite cases embodying the supposed differences among the circuits. Phantom conflicts do not justify certiorari review.

B. CERTIORARI SHOULD NOT ISSUE REGARDING PETITIONER'S MOTION UNDER FED. R. CIV. P. 59(e).

Following the district court's entry of summary judgment against petitioner on her breach of contract and tort claims, petitioner filed a motion to reconsider which sought to introduce what she claimed was "new" evidence. (Pet. App. at A-11-17.) Petitioner later specifically asked the district court to accept her motion to reconsider as a motion to alter or amend the judgment under Fed. R. Civ. P. 59(e). (Pet. App. at A-22.) The district court granted plaintiff's request to treat the motion to reconsider under Rule 59(e), but declined to change its ruling. (Pet. App. at A-22-28.) The Tenth Circuit affirmed. (Pet. App. at A-39.)

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its decision was in any part based on Security General's continued payments to petitioner. (*See infra* at 6.) This had been a basis of the district court's decision (Pet. App. at A-7), but the Tenth Circuit affirmed summary judgment not because of the continued payments, but rather because the contract authorized the termination of coverage. (Pet. App. at A-35-36.) Moreover, even the district court's decision was consistent with *Berry*. Although in *Berry* the insurer initially refused to pay claims, in this case the district court found that benefits were paid without any interruption at all, and that the contract was never breached. (Pet. App. at A-4, A-7, A-9.) Under these circumstances, no cause of action arises even under the *Berry* decision. No conflict exists.

Petitioner now claims – for the first time ever – that the courts below erred by failing to apply an "excusable neglect" standard under Fed. R. Civ. P. 6(b). (Pet. at 8) (citing *Pioneer Inv. Services v. Brunswick Associates*, ___ U.S. ___, 113 S.Ct. 1489 (1993)). No basis is shown for granting certiorari. Petitioner waived any application of the Rule 6(b) standard by specifically asking the district court to treat her motion to reconsider under Rule 59(e) and by not raising any Rule 6(b) issues before the Tenth Circuit. Moreover, Rule 6(b) is inapplicable. Rule 6(b) governs situations where "by order of court an act is required or allowed to be done within a specified time." The issue here instead involves whether petitioner should have been allowed to supplement her post-judgment motion with additional evidence that was not part of the record – a situation governed by Rule 59(e).

In any event, the specific evidence offered in the motion to reconsider was irrelevant. (Pet. App. at A-39.) The determination of relevance hinged on the Tenth Circuit's correct application of contract language providing that Security General had the right to terminate the policy for any reason other than the deterioration of an individual insured's health. (Pet. App. at A-36-37, 39.) The Tenth Circuit's determination that petitioner's evidence was irrelevant involves no special or important issue which would support a granting of certiorari. *See United States v. Johnson*, 268 U.S. 220, 227 (1925) ("We do not grant certiorari to review evidence and discuss specific facts.").

C. CERTIORARI SHOULD NOT ISSUE TO REVIEW THE TENTH CIRCUIT'S READING OF THE CLEAR LANGUAGE OF A STATE STATUTE.

Petitioner asks this court to review the Tenth Circuit's holding that Colo. Rev. Stat. §§ 10-8-116(2)(b)(V) and -116(3) by their terms apply only to policies delivered or issued for delivery in Colorado. (These provisions are set out verbatim in Appendix A.) There are no special or important reasons for this Court to review issues concerning the proper reading of this state statute.

Petitioner also claims that the applicability of these statutes depends upon general choice of law principles, such as whether Colorado had a "significant relationship" with the transaction. (Pet. at 11.) Under the choice of law method prevailing in Colorado, however, the legislative directive that the statute apply only to policies delivered or issued for delivery in Colorado takes precedence over general choice of law rules and must be followed. *See Restatement (Second) of Conflicts of Laws* § 6(1) *(quoted in Wood Bros. Homes, Inc. v. Walker Adj. Bureau,* 198 Colo. 444, 601 P.2d 1369, 1372 n.3 (1979)). The evidence was undisputed that the policy was not delivered in Colorado. (Pet. App. at A-34.) Although a certificate of insurance was delivered to petitioner in Colorado, the delivery of a certificate is not tantamount to the delivery of a policy. *New England Mut. Life Ins. Co. v. Gray,* 786 F.2d 406, 408-09 (6th Cir. 1986). No choice of law issue exists.

D. CERTIORARI SHOULD NOT ISSUE TO REVIEW A MATTER NOT DETERMINED BY THE COURT BELOW.

Petitioner finally asserts that the Tenth Circuit erred in holding "that reinstatement of benefits following institution of a bad faith tort action renders the action moot." (Pet. at 12.) But no such holding or remotely similar ruling appears anywhere in the Tenth Circuit's decision. Summary judgment was affirmed not because petitioner continued to receive benefits (although she did), but rather because Security General by contract had the right to terminate the policy for any reason other than the deterioration of an individual insured's health. (Pet. App. at A-35-36.) Certiorari should not issue for the wholly academic purpose of reviewing a matter which was never considered by the court below. *See Rice v. Sioux City Memorial Park Cemetery,* 349 U.S. 70, 74 (1955) (certiorari review not exercised to resolve academic issues or to benefit particular litigants).

CONCLUSION

For these reasons, the Petition for Certiorari should be denied.

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Respectfully submitted,

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APPENDIX A

C.R.S. § 10-8-116(2)(b)(V), now codified at C.R.S. § 10-16-108(1)(a) (Cum. Supp. 1992), provides:

> If the group insurance policy provides hospital, surgical, or major medical insurance or any combination of these coverages on an expense-incurred basis, for other than specified diseases or accidental injuries only, it shall also contain a conversion privilege conforming to the requirements of subsection (3) of this section.

C.R.S. § 10-8-116(3)(a), now codified at C.R.S. § 10-16-108(1)(c)(I) (Cum. Supp. 1992), provides:

> A group policy delivered or issued for delivery in this state which provides hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis, but not including a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class or failure of the employee or member to pay any required contribution and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination is entitled to have issued to him by the insurer a policy of sickness and accident insurance, referred to in this subsection (3) as the "converted policy". . . .